BENEFIT CHOICE ELECTION FORM

XXXXX – XXXXX, 2004 (Changes effective XXXXX, 2004)

COMPLETE ONLY IF YOU ARE MAKING A CHANGE

Forms available at www.xxxxxxx.xxx

SECTION A: EMPLOYEE INFORMATION (required)

Social Security Number	Last Name	First Name	Phone Numbers
- -			Home:
			Work:

SECTION B: EMPLOYEE HEALTH & DENTAL (complete only if changing health or dental coverage)

(1) If you are changing to a managed care plan from Quality Care, or if you are changing to a different managed care plan, you must enter the 6-digit Primary Care Physician (PCP) number or Primary Care Dentist (PCD) number.

(2) If you have Medicare or other insurance, you must give your GIR or GIP a copy of your Medicare/other insurance card.

Opt Out/Opt In of Health & Dental Coverage (must provide proof of other comprehensive health coverage to opt out)		
○ Opt Out	○ Opt In	To opt out or opt in, you must complete the Opt Out & Opt In Election Certificate (CMS-500). Submit the completed CMS-500, along with this Benefit Choice Election Form, to your GIR or GIP.

Health Plan Election			
○ Quality Care	○ Managed Care	Managed Care Name:	PCP #:
Dental Plan Election			
○ Quality Care	○ Managed Care		PCD #:

SECTION C: EMPLOYEE OPTIONAL LIFE INSURANCE (complete this section only if changing life coverage elections)

(1) A Statement of Health form is required if adding Optional Life (form available at www.xxxxxxxx.xxx).

Employee Optional Life: ○ Increase ○ Decrease			Accidental Death & Dismemberment (AD&D)	
○ Cancel Optional Life	○ 1x Basic	○ 3 x Basic	○ Cancel AD&D	○ BASIC only (1 x Basic)
	○ 2x Basic	○ 4 x Basic		○ COMBINED (Basic + Optional Life)

SECTION D: DEPENDENT HEALTH, DENTAL & LIFE (dependent must enroll in the same plans as member)

(1) You must provide documentation to add dependents – see the back of this form for specific documentation requirements.

(2) If the dependent has Medicare or other insurance, you must give your GIR or GIP a copy of the Medicare/other insurance card.

(3) If you are changing to a managed care plan from the Quality Care plan, or if you are changing to a different managed care plan, you must enter a Primary Care Physician (PCP) or Primary Care Dentist (PCD) 6-digit number for each dependent in your plan.

(4) A Statement of Health form is required if adding Spouse or Child Life (form available at www.xxxxxxxx.xxx).

Health Dental Vision		Life ($5000)		Name	SSN	Birth Date	Relationship *	Primary Care Physician #	Primary Care Dentist #
Add	Drop	Add	Drop						
○	○	○	○						
○	○	○	○						
○	○	○	○						
○	○	○	○						
○	○	○	○						

***** Spouse, son, daughter, stepchild, adopted child

I authorize prevailing premiums to be deducted from my pay or annuity for those coverages I have selected. This authorization will remain in effect until I provide written notice to the contrary. The information contained in this form is complete and true. I agree to abide by all Group Insurance Program rules. I agree to furnish any additional informational if requested.

MEMBER SIGNATURE: _____ DATE: _____

GIR/GIP SIGNATURE: _____ DATE: _____

Give completed form to your Group Insurance Representative/Preparer in your Benefits Office by XXXX, 2004.